Magnetic Resonance Research Center
300 Cedar Street
New Haven, CT 06510

MRI COVID Questionnaire

Name: ______________________ **Date of birth:** ______________________

Today's date: ______________________

Please read the following questions carefully. It is very important for us to know if you might have Covid. If you do not understand a question, please ask us to explain! If you answer yes to any question, please contact the principal investigator.

1. Yes ☐ No☐ Do you have COVID?
2. Yes ☐ No☐ Have you been around anyone recently who has Covid?
3. Yes ☐ No☐ Did you have a fever?
4. Yes ☐ No☐ Do you have chills?
5. Yes ☐ No☐ Do you have night sweats?
6. Yes ☐ No☐ Do you have a cough?
7. Yes ☐ No☐ Do you have shortness of breath?
8. Yes ☐ No☐ Do you have muscle pain?
9. Yes ☐ No☐ Do you have joint pain?
10. Yes ☐ No☐ Do you have a headache?
11. Yes ☐ No☐ Do you have diarrhea?
12. Yes ☐ No☐ Do you have eye pain?
13. Yes ☐ No☐ Do you have a recent change or decrease in sense of smell?
14. Yes ☐ No☐ Do you have a recent change or decrease in sense of taste?

Signature: ______________________________ **Date:** ______________________